Minutes
Housing Workgroup
1/22/2007

Present: Victor Greenwood, Donna Kelley, Sheldon Wheeler, Artha Freebury, Rose Marie Charest.

Topic: Focus on Scenario Development—1601 Intensive Residential Services

Next Meeting: Continue discussion on scenario development to include 1602 Community Residential Services and 1603 Supported Housing as defined by the workgroup's previous efforts. With note that some persons will not be able to make the meeting scheduled for 1/29, those not available will have opportunity in future meetings to provide input to further flesh out the scenario development work within each of these categories.

1601 Intensive Residential Services

1. From Higher Level to Intensive Residential Services
    a. Consumer Perspective
        i. Current priorities for placement into Intensive Resi Housing appear to be: State Psychiatric Facilities (RPC/DD) followed by Private Psychiatric Hospital referrals, followed by very long provider wait list that can extend up to 2 years in the community
        ii. Consumers report of being told of a bed(s) available but not for them--with their particular needs.

    b. Provider Perspective
        i. All placements are (are supposed to be) screened and approved by the regional Mental Health Teams. Providers echoed consumer perspective regarding impression of existing priority placements. Existing clients of Riverview and Dorothy Dix, followed by persons in Private Psychiatric Hospitals and then by persons from community based settings—with Class Members having priority in each category.
        ii. Units can remain vacant or held open for extended periods while hospital placement and discharge planning efforts are underway. This is distinct from Bed Hold days and does not include provider payment during these periods.

2. From Community Settings to Intensive Residential Placement
    a. Consumer Perspective

i. Persons can not get into a needed program without a hospital admission. Hospital discharge staff seem to have more access to these resources, or clout, in moving persons into Intensive Residential placements than staff from community mental health and resource centers.
ii. Persons with co-occurring medical face additional placement challenges in these group home settings which are often not able to accommodate their additional physical needs.

b. Provider Perspective
    i. Typically entrance into Intensive Residential Services programs from the community come from homeless housing and services programs funded by HUD.
    ii. Otherwise, persons are put on a waitlist…often times the current situation is at a point where consumers and providers do not even apply because their experience is that there are no openings.
        1. This topic generated much discussion with respect to the need and responsibility of both the consumer and the provider to document needs—even if the resource is not available at the time. Sheldon gave the example of the BRAP (Bridging Rental Assistance Program) where several years ago BRAP was the only Mental Health Program to receive an increase in funding which more than doubled the previous year's allocation. This was due in very large part to documenting the need, analyzing the current utilization, and demonstrating the existing and future growth of the resource. None of this could have happened if nobody bothered to record the need—placing persons on a waitlist.

3. To Higher Level from Intensive Residential Placement
    a. Consumer Perspective
        i. Much of the discussion surrounded persons who are 'stuck' because their medical needs warrant a nursing type or level of care while there is still a need for mental health support. Options are typically few or nonexistent. The result is persons are essentially locked out of their home (they are in a nursing home and can't get back) or they stay in a group home setting without their physical needs being adequately met.

    b. Provider Perspective
        i. Bed hold days (where a person needs a temporary placement in a hospital or nursing home and their bed is 'held' open for them)

represent a good vehicle for keeping stability from both a program and consumer perspective.

ii. Agree with consumer perspective regarding persons with co-occurring medical issues. The system needs a increased availability and options for assisted living/nursing and rehab facility levels of care that can accommodate both mental health and physical needs. Many of these facilities do not currently accept mental health consumers because they are equipped to address medical, not mental health needs.

4. To Community from Intensive Residential Placement
    a. Consumer Perspective
        i. No service currently available that can quickly ramp up care if there is a need…given current situation, this is a huge step particularly knowing that re-entry into this level may require a hospitalization. This situation may result in persons staying in these programs longer than they really need to.

    b. Provider Prospective
        i. Depending on the type and configuration of the Intensive Residential Services program, there can be very different outcomes regarding community placement.
            1. For example, if the program and services are only delivered through one facility there is a natural either/or situation—either the client moves into an apartment setting with lesser services or they remain in the group home living arrangement.
            2. However, if the program and services are delivered through one facility <u>with</u> additional support for apartment living in proximity to the core facility, then the person can move into the apartment setting with the assurance of 24/7 support when needed.
                a. This increasingly utilized model in Maine (funded via PNMI and often rental subsidies) represents a balance in the transition from group level of care to more independent, community based environments where services ebb and flow without the severity of being ‘cut-off’ to an entire cadre of care that may not be available in existing community based services.